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Maine Health Homes Stage B Request for Information: Questions and Answers

Provider Standards and Requirements

1. **What will be the vetting and selection process for Stage B CCTs?**

MaineCare will have an application process that allows any willing provider to apply and become eligible to provide the service.

2. **Can a provider deliver Stage B Health Home services in locations where there is a relationship with a primary care provider and also offer Stage B CCT services to other Stage B Health Homes?**

As in Stage A, Behavioral Health CCTs (BH CCTs) will need to develop partnerships with multiple primary care providers in order to address the needs of their members. These partnerships may take a variety of forms, including facilitated referral, co-location, and/or in-house rendering physicians that are paid by the Behavioral Health CCT.

3. **How do existing CCTs qualify to apply?**

Any provider that applies and meets criteria will be able to deliver these services.

4. **Stage B Health Homes will consist of partnerships between primary care and CCTs. Does this imply that the community mental health center may become the CCT or do we need to utilize existing CCTs?**

Community mental health centers that meet the criteria developed for Stage B CCTs may become BH CCTs in Stage B.

5. **Why is the DHHS preventing behavioral health providers from delivering both Health Home services and TCM and/or CI? This is in contrast to the model established in Stage A. Primary care practices do not receive the additional payment for being a health home if an individual declines that service, but the primary care provider can continue to provide primary care services. Preventing providers from delivering both services creates an issue with choice. Please explain the rationale for preventing a provider from delivering both services.**

Additional response on this issue will be forthcoming. MaineCare is still exploring options, specifically regarding how best to support consumer choice while promoting system transformation. MaineCare will share this additional information with stakeholders as soon as possible.

6. **Will there be a limit to the number of Stage B CCT's across the state or in a particular region?**

No.

7. **What demonstrated expertise and qualifications will be required of a current Stage A CCT applying to be a Stage B CCT, and what will be the acceptable means of demonstrating both the expertise and qualifications?**

   This RFI is seeking input on this question; we welcome your recommendations and comments**.**

8. **Are there minimum standards and requirements required under ACA Section 2703 which have not been described in this announcement?**

Federal regulations have not yet been developed for Health Homes. Section 2703 of the ACA, along with current federal guidance, are available at the CMS website.

9. **Since behavioral health providers are already extremely regulated, carefully licensed and audited, and often nationally accredited, wouldn't those existing demonstrations of expertise and quality be enough to qualify as having "extensive expertise" in mental health services?**

This RFI seeks input on these and other issues. Please submit your detailed comments on criteria as part of your RFI submission.

10. **"The Health Home model under Stage A consists of a designated patient-centered medical home practice (the "Health Home practice") that partners with a Community Care Team (CCT) to jointly provide Health Home services to eligible MaineCare members." It seems that the Stage B design does not enable behavioral health providers to be the "Health Home practice," but instead they could serve as a Community Care Team. If that is accurate, who is considered to be the Health Home practice?**

Health Homes in both Stage A and B consist of the partnership between a primary care practice and a CCT. These partnerships may take a variety of forms, including facilitated referral, co-location, and/or in-house rendering physicians that are paid by the BH CCT. This RFI seeks input on who these primary care practices can/should be.

In Stage A, individuals are assigned to the Health Home based on their relationship with a Patient-Centered Medical Home (PCMH) practice. In Stage B, this relationship will consist of a primary care practice and a CCT with extensive expertise in community mental health (the Behavioral Health CCT). Assignment will be based on the member's relationship to the Behavioral Health CCT.

11. **Can a behavioral health provider segment its services by location/geography such that some components of the agency will deliver Stage B CCT services to Health Home members and other components of the agency will deliver Section 17.04-1 or 13.03-3 (A) services to other members?**

Additional response on this issue will be forthcoming. MaineCare is still exploring options, specifically regarding how best to support consumer choice while promoting system transformation. MaineCare will share this additional information with stakeholders as soon as possible.

12. **Question 1 asks about learning from ACT teams and Wraparound services in the state. Why not add "and through the nationally emerging models in treating children with SED" after the word "state"?**

Thank you for the suggestion, and if you have particular practices that you would like to see reviewed as a part of this process, please indicate in your RFI comments.

13. **On p. 4, you state that "…the Department is proposing that Stage B Health Homes integrate the services described in Section 17.04-1 Community Integration for adults and Section 13.03(A) Targeted Case Management Services for Children with SED into the service structure of the Health Home. Accordingly, providers who elect to become a**

Stage B CCT will no longer deliver services under Section 17.04-1 Community Integration (CI) for adults or Section 13.03(A) Targeted Case Management Services (TCM) for Children with SED if they are also providing Health Home services to those populations. Stage B CCT services will take the place of Community Integration for Adults and Targeted Case Management for children's behavioral health for eligible members who choose to receive services through these organizations." The MaineCare Regulations reference for Chapter II, Section 13, 13-03 (A) is not an accurate, identifiable reference in the table of contents. Do you mean Section 13-03-3(A), Case Management Services for Children, Eligibility Criteria for Children with Behavioral Health Disorders? If not, then please confirm the specific reference.

Yes, that was the intended reference.

14. **On p. 5, you state that "For providers that choose to participate in this new service, we anticipate a period of time for capacity-building and system transition." How much time do you anticipate that you will tolerate capacity building and system transition? Must all current providers agree to become Stage B Health Homes or give up their service provision to Stage B CCTs and other Stage B health homes? What does a "period of time for capacity building and system transition" mean in relation to the enhanced payment to be expected from the Federal government in terms of Health Home services?**

MaineCare recognizes that the transformation to Health Homes in Stage B will need time and resources. MaineCare has an obligation to ensure that all Health Home providers are in compliance with organizational and service delivery requirements as described in the State Plan Amendment that is approved by CMS for the service. MaineCare anticipates that, as in Stage A, service providers will be required to meet certain minimum criteria *and* provide quarterly reports that document progress toward full implementation of all core measures by the end of the first year of operation. MaineCare's intention is to work collaboratively with practices and BH CCTs to support this work.

15. **Pg 3. – Stage B Health Homes (paragraph 2) – The Department's goal is to build upon existing resources…Does this mean that the department is willing to expand the role of our existing case managers to incorporate the functions of care management?**

Existing case management services and the existing CCT system may be valuable resources for Stage B. However, neither of these existing service systems has all of the requirements needed to become a Behavioral CCT as part of a Stage B Health Home. Providers will need to demonstrate both an expertise in community mental health care, and the ability and commitment to provide care management that addresses complex physical health needs as well.

16. **Are the "existing resources and infrastructure" contemplated in the current TCM and ACT delivery systems or is the term "infrastructure" being used in a broader sense?**

Infrastructure includes TCM, Community integration, Community Care Teams, Stage A Health Home practices, and existing integrated care pilots, such as those funded by MeHAF and SAMHSA. The language signals an interest in building on existing strengths and expertise, rather than creating entirely new systems of care.

17. **Pg 3. – Stage B Health Homes (paragraph 2) – "…and at the same time promote the delivery system transformation needed to improve health outcomes and lower cost." Will the department consider allowing function to drive the performance of the team members rather than credential?**

Please provide specific recommendations as part of your RFI comments

18. **Is CCT the new name for Behavioral Health Homes, or are they distinct entities? Assuming that eligibility is going to be driven by functional impairment, what tool(s) will be utilized to indicate appropriate attribution?**

Behavioral Health CCTs are a central component of Stage B Behavioral Health Homes. Stage B Health Homes, similar to Stage A Health Homes, consist of primary care and a Behavioral Health CCT.

19. What entity will be responsible for approving/selecting CCTs for Stage B?

MaineCare will determine criteria, develop and release the application, and review and approve Stage B Health Homes.

20. How does the Department define extensive expertise for care management for adults and/or children with co-occurring disorders?

MaineCare is looking for comments on this issue through this RFI and welcomes your feedback.

21. What demonstrated expertise and qualifications will be required of a current Stage A CCT applying to be a Stage B CCT, and what will be the acceptable means of demonstrating both the expertise and qualifications?

MaineCare is looking for comments on this issue through this RFI and welcomes your feedback.

22. If DHHS has determined that it will transition the current thinking on the Stage A & B models from one of diagnostic eligibility to one of functional eligibility, will the standards of expertise regarding co-occurring be the same for both Stage A and Stage B?

Current Stage A criteria does not address standards of expertise for co-occurring disorders (assuming mental health and substance abuse). Stage B will require some level of expertise in this area, although that has not yet been determined. Feedback on this is welcome.

23. Under paragraph 3 of the Minimum Requirements, do the "partnerships with primary care providers" need to be in place at the time of application to be a Stage B CCT or is there an intended timeframe by which a Stage B CCT would need to establish partnerships with primary care providers?

It is unlikely that BH CCTs will have all necessary PCP partnerships in place. However, providers may be expected to have processes in place that describe plans for outreach, communication, and potential partnership arrangements with these practices. These partnerships may take a variety of forms, including facilitated referral, co-location, and/or in-house rendering physicians that are paid by the BH CCT. This RFI seeks input on who these primary care providers can/should be.

24. Can a Stage B CCT have partnership arrangements with multiple primary care practices? Given the current barriers to PCP – member relationships, it seems this model will only work if the Stage B CCT's are partnered with many different primary care practices.

Behavioral Health CCTs, as in Stage A, may have agreements with multiple primary care providers.

25. Can the Department be more specific in terms of the # of months or years it envisions for the Stage B Health Home Core Standards to be met?

MaineCare has an obligation to ensure that all Health Home providers are in compliance with organizational and service delivery requirements as described in the State Plan Amendment that is approved by CMS for the service. MaineCare anticipates that, as in Stage A, service providers will be required to meet certain minimum criteria *and* provide quarterly reports that document progress toward full implementation of all core measures by the end of the first year of operation. MaineCare's intention is to work collaboratively with practices and BH CCTs to support this work.

26. Why would MaineCare want to dictate the "kinds of partnership structures" when creating and maintaining relationships with PCPs is already so difficult for the population of adults with serious mental illness and children with serious emotional disturbance?

MaineCare will be incentivizing both primary care and Behavioral Health CCTs to participate in these kinds of partnerships; MaineCare has not dictated the structure of these partnerships, but is looking for feedback with this RFI on how best to design and facilitate these arrangements. These partnerships may take a variety of forms, including facilitated referral, co-location, and/or in-house rendering physicians that are paid by the BH CCT. This RFI seeks input on who these primary care providers can/should be.

27. Under Minimum Standards for Stage B CCT's, paragraph 2 (a) and (b) require demonstrated capacity to provide "comprehensive care management" and "care coordination and health promotion." How does the Department differentiate between comprehensive care management and care coordination? Does the Department consider care coordination to be a component of comprehensive care management?

Yes; care management refers to a broader set of activities that includes coordination and management of all aspects of an individual's health-related care, including medical care.

28. Can the Department provide a non-exhaustive list of those services contemplated in "comprehensive care management", "care coordination and health promotion", "comprehensive transitional care from inpatient to other settings" and "individual and family support"?

MaineCare has not yet developed these definitions for Stage B.

Why doesn't the question also ask about demonstration of "extensive expertise" in co-occurring services since both are required elements of a Stage B Health Home?

Thank you for that suggestion; please feel free to include this in your RFI comments.

Payment Models

29. On p. 9, #3, you ask "What non-reimbursement tools/supports could assist you and/or your organization to better integrate behavioral and primary care in order to more effectively serve people with serious mental health and co-occurring disorders (may include telepsychiatry or psychiatric consultation, changes in licensing, resolution of privacy concerns, additional training, etc.)?" Please define what you mean by non reimbursement tools/supports in more detail.

Non-reimbursement tools or supports would be, as described, those services, training, tools, systems or other supports that are not built into a reimbursement rate, but that assist the provider in delivering integrated care, or remove existing barriers to integrated care.

30. What is the PMPM rate, and what does it cover?

Similar to Stage A, the PMPM rate for Stage B will be calculated based on staffing and caseload expectations.

31. How will a behavioral health provider be able to apply to be a CCT for Stage B Health Homes if the RFI doesn't explicitly delineate the reimbursement rates? If those rates are not available as part of the RFI, it will be

impossible to know if an organization can cover the cost of delivering the more comprehensive Stage B CCT services.

The RFI is an opportunity to comment on the model and provide input, including an informal and understandably preliminary indication of interest from potential providers. Additional information, including MaineCare recommendations developed from the RFI process, the State Plan Amendment, MaineCare regulation, provider education materials, and the application itself will be provided prior to the formal application process**.**

32. Does becoming a Behavioral Health Home change the current structure of funding for services (will providers continue to bill fee for service and receive an additional payment as is the case in Stage A or is there an entirely different structure being proposed for Stage B?).

MaineCare anticipates that, similar to Stage A, Behavioral Health Home providers (the practice and the BH CCT) will receive a per member, per month payment for each member assigned to the Health Home for Health Home services. Non-Health Home services currently covered by MaineCare will continue to be reimbursed on a fee-for-service basis.

33. What is the population size that is required to become a CCT in order for the reimbursement to support the structure?

MaineCare has not considered a minimum population size at this time.

34. Are there caps on the number of individuals that may be served by a BHH?

No.

35. Are there caps on the # hours/month or week for individuals served?

No.

36. How will the payments be structured for primary care providers who participate as part of a behavioral health home? Assuming that Primary Care Providers will be involved in different relationships with different consumers will there be a tier system of payment for PCP involvement in Stage B.

We expect a primary care provider to commit to a minimum level of care/activity as reimbursement for the PMPM payment under Health Homes.

Is the funding methodology robust enough to provide the same level of support that a member currently receives from their TCM or CI service for the Case Management function, assuming there will be additional revenue for care coordination?

The funding methodology will take into account the additional capacity required for the new service.

37. What billing code or structural service delivery changes could the Department make to allow more flexibility with current non-billable hours as part of the Health Home service?

When billing under a PMPM methodology (as opposed to 15 minute increments) providers are expected to manage their time according to the goals and needs of the consumers on their caseload.

Core Components

38. What is the primary function of a Stage B Health Home (care management vs service delivery). For example, if a CCT has a licensed social worker, does that social worker provide long-term therapy services or does the CCT link with existing behavioral health resources?

Per Section 2704 of the ACA, Health Home services consist of the following:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- Patient and family support (including authorized representatives);
- Referral to community and social support services, if relevant; and
- Use of health information technology to link services, as feasible and appropriate.

These services will be described further in the Maine SPA and MaineCare regulation. Services that do not meet the definition (such as long-term therapy) will need to be provided outside of the BH CCT.

39. How does the current practice for children TCM of child and family teams play into the CCT or Health Home?

Team-based care is a core feature of the Health Home model, so MaineCare sees alignment between these models and Health Homes. Additional thoughts on these models and their value in Health Home design would be welcome in your comments.

Rights of Recipients

40. Are there any conflicts with the consent decree that need to be factored into the Stage B design?

MaineCare is seeking comment on this issue as part of the RFI, in addition to conducting its own review.

41. Will the RFI or SPA seek to ask or refer to Maine's Adult Mental Health Bates v Mayhew Consent Center?

MaineCare does not plan to reference Bates v Mayhew in the State Plan Amendment, but these requirements and obligations will be an integral part of the planning and development process.

42. **Will class members of the Consent Decree who are eligible for Section 17-01 CIS (Case Management) Services without regard to diagnosis or meeting the severity measure of GAF score for service, be eligible to receive BHH Services?**

Yes.

Data Sharing, Data Analytics, HIT

43. Will we be able to access "all payer" information such that we can truly assess and reduce the overall healthcare spending per consumer? All healthcare service contacts need to roll up within such reporting to ensure an accurate picture of current utilization.

MaineCare will develop utilization reports based on MaineCare claims data and other tools to assist providers with identifying members with high needs or emerging care coordination issues.

44. What data capacity and quality measures does the Department anticipate in the new model?

MaineCare will require data capacity sufficient to perform core functions across the Health Home, including the ability to manage the health of assigned MaineCare members using population-based management tools and to report on key clinical quality measures as required by CMS and/or MaineCare. We welcome your feedback on quality measures.

HIT/EMR

45. Does the Department anticipate providing resources to help behavioral health providers (who become Stage B CCT's) to bring their EMR systems to meet minimum OR core requirements? Can the final RFI specify what financial support the Department can and will provide to behavioral health providers who become Stage B CCT's to set up and maintain the infrastructure & staffing needed to implement such a new model of payment and quality measurement?

As part of the SIM grant, MaineCare will provide quality improvement resources, work force development and training, and support for the build out and/or enhancement of HIT systems for behavioral health providers. These efforts will align with and support the Stage B Health Home effort.

46. With regard to Core Standard #10, what criteria will the Department use to determine if a Stage B Health Home has met the standard of "integration and use of Health Information Technology (HIT) into care"?

MaineCare will develop expectations and definitions for each of the core requirements. MaineCare anticipates an evolution in provider ability to meet standards over time.

47. Under paragraph 4 of the Minimum Requirements, can the Department further define its intent for a Stage B CCTs Electronic Health Record capabilities at application? Can a behavioral health agency become a Stage B CCT if its Electronic Health Record is in transition from one system to another more robust system, understanding that full implementation of a new system can take 1-2 years?

Given the varying levels of HIT capacity, MaineCare anticipates a ramp up period. We welcome your feedback on this issue.

48. Under paragraph 2(f) of the Minimum Requirements, how does the Department define "feasible and appropriate" use of Health Information Technology?

Specific requirements have not yet been identified, but MaineCare anticipates a ramp up period.

Member Assignment, Consumer Choice, Eligibility, Duplication

Consumer Choice

49. Question 2 asks about promoting/enhancing "consumer rights, consumer involvement, and a consumer directed approach to care." The current RFI restricts consumer choice because a member receiving TCM/ACT services from a provider that becomes a Stage B CCT would not be able to choose to stay with his/her current TCM/ACT provider if he/she wants Health Home services. Would the Department consider promoting consumer choice by permitting the provider to offer Stage B CCT services and ALSO continue to directly provide 17.04-1 and 13.03-3(a) services to different members?

Additional response on this issue will be forthcoming. MaineCare is still exploring options, specifically regarding how best to support consumer choice while promoting system transformation. MaineCare will share this additional information with stakeholders as soon as possible.

50. How will patients be served if they opt out of the Health Home and a provider is prohibited from offering the services if they are a Stage B Health home? Will they be forced to transition to another provider? If so, how is that reconciled with the desire to preserve consumer choice?

Additional response on this issue will be forthcoming. MaineCare is still exploring options, specifically regarding how best to support consumer choice while promoting system transformation. MaineCare will share this additional information with stakeholders as soon as possible.

51. If a member receiving 17.04-1 or 13.03-3(A) services is designated as Stage B Health Home eligible, but chooses not to participate in the Health Home, can he/she continue accessing 17.04-1 or 13.03-3(A) services through their current behavioral health provider if the provider is a Stage B CCT?

Additional response on this issue will be forthcoming. MaineCare is still exploring options, specifically regarding how best to support consumer choice while promoting system transformation. MaineCare will share this additional information with stakeholders as soon as possible.

52. In terms of consumer choice, how will the department maintain consumer choice for members who are receiving adult ACT or children's TCM for behavioral health, and who are then offered health home services, but want to maintain their relationships with their current ACT or TCM providers and NOT participate in the BHH, if their provider is a BHH?

The role of ACT has not yet been defined in Stage B. However, please refer to the previous responses regarding consumer choice.

53. Will MaineCare members who qualify as a person with a SMI or SED and choose to opt out from being assigned to a BHH be able to or prevented from participating with a BHH after any defined time period?

Eligible individuals may join the Health Home at any time.

54. How can the Department ensure that there will be no disruption in mental health (ACT/TCM) services if a member learns they have been assigned to a Stage B Health Home and either a) do not understand what it means, or b) refuse the Health Home service?

Member education and support will be a critical component in this transition, and we expect that members will need significant information in a variety of formats prior to assignment. As noted in previous responses, MaineCare also continues to explore options, specifically regarding how best to support consumer choice while promoting system transformation. MaineCare will share this additional information with stakeholders as soon as possible.

55. Pg. 4 – Mainecare members may choose not to participate in Health Home services. If they choose not to participate, does this impact their benefits? Can they choose a Stage A Health Home if they are deemed eligible for a Stage B health home?

Choosing not to participate in Health Homes does not impact MaineCare benefits. CMS requires Health Home State Plan Amendments to clearly define the population served. Consequently, eligibility for Stage A and Stage B are mutually exclusive. However, members may receive primary care at any participating Health Home practice and receive all the benefits of the Patient-Centered Medical Home. The practice will not receive payment for the member if they decline Health Home services, but the processes in place that enhance that model of primary care will all be available to them.

Assignment

56. On p. 4, you state that "…in Stage B the primary access point for the majority of individuals with SMI and SED will be through the Stage B CCT." Will Stage B CCTs be assigned Stage B Health Home patients as are Stage A Health Homes who are currently assigned patients and what is the payment for Stage B CCTs? Please be specific and explain how you envision this will occur using a real life example.

In Stage A, patients are assigned via the Health Home Practice. In Stage B, the current thinking is that assignment will happen via the Behavioral Health CCT. BH CCTs that have an existing caseload may be assigned members who are eligible for the service, and interested in becoming a Health Home member. Payment for Stage B Health Homes has not yet been determined for either the practice or the BH CCT.

57. **If "the primary access point for the majority of individuals with SMI and SED will be through the Stage B CCT", does this mean that a similar attribution process as in Stage A will occur only the view will be to place the member with the Stage B CCT where he/she received the plurality of services in the look back?**

Yes.

58. If the department is assigning members based on the services they currently use, will we be able to accept referrals from consumers and providers directly, or will all referrals have to come through the Department?

Providers may still receive referral directly.

59. "The Department plans to assign members to Stage B Health Homes based on the services they currently use." If the member is being assigned to a CCT, how is this selection made if the consumer receives services from a provider who has not applied for or chosen to become a CCT?

Members who are not assigned via service use will receive information about Health Homes and a list of participating providers. He/she may choose to receive the service from a participating Health Home provider or stay with his/her current provider.

60. Does the statement, "…in Stage B the primary access point for the majority of individuals with SMI and SED will be through the Stage B CCT" mean that attribution of a member occurs with the Community Care Team and not the primary care practice?

Current thinking is that members will be attributed to the Health Home via the BH CCT.

61. What is the attribution/attestation process to determine which members are included in BHHs?

Similar to Stage A, members eligible for Health Home services will be attributed to the Health Home based on their existing relationship with the Health Home provider. In contrast to stage A, MaineCare anticipates that assignment will be based on the relationship with the BH CCT. Members who do not have an existing relationship with a BH CCT will have a choice of providers. Members may always opt out of the service if they choose.

62. On page 4 it is stated that members may choose to not participate in Health Home services. On page 10, it is stated that the Department plans to assign members in order to appropriately calculate payments, track utilization and accurately measure quality and performance. On the National level, much of the discussion focuses on the difficulty in providing Health Home services to assigned members who do not want to participate or interact with the Health Home staff. There is significant concern that these clients will negatively impact a Health Homes outcome and reduce any potential shared savings. How does the Department plan to allow these clients to opt out of the Stage B Health Homes and to assure their medical cost do not negatively impact the Health Home's outcome measures and reimbursement?

Health Home providers will not be responsible for outcomes from members who are not assigned to the Health Home. Mainecare expects that additional flexibility in payment and design will allow Health Homes to provide outreach and engagement to members who are assigned to a Health Home but may not engage initially.

Eligibility

63. Does the OMS have a reference for the definition of SMI and SED it will use for its SPA?

As an initial assignment to services, MaineCare will be using utilization of certain services to identify eligible Health Home members. A list of these services is attached as Appendix A. MaineCare will also develop stand-alone criteria for members who are new to services; this eligibility criteria will align with eligibility for the services listed in Appendix A – i.e., service criteria for Health Homes will not be more stringent than the criteria for these services.

64. If the answer is no,Is OMS seeking from respondents to the RFI, definitions of these populations?

Eligibility is not a focus for this RFI.

65. What are the criteria for determining if a member is 'qualified' to be at a BHH? Do ALL children who qualify for TCM chapter 13 under behavioral health 'qualify' for the BHH-CCT? Or just the high cost children/adults?

At this time, MaineCare is not limiting Stage B Health Homes to specific high-cost users of service. Eligibility criteria include the broader population currently eligible for certain behavioral health services (see Appendix A). Mainecare is reviewing how best to serve the needs of children who currently use TCM through Health Homes.

66. What criteria will be used to determine that a child with serious emotional disturbance qualifies for Stage B Health Home services? What criteria will be used to determine that an adult with serious mental illness qualifies for Stage B Health Home services?

Members using services outlined in Appendix A will be eligible for Stage B services. Additional eligibility criteria will also be developed for new members accessing the service. This eligibility criteria will align with eligibility for the services

listed in Appendix A – i.e., service criteria for Health Homes will not be more stringent than the criteria for these services. MaineCare is reviewing how best to serve the needs of children who currently use TCM through Health Homes.

Duplication/TCM

67. Will MaineCare Members who choose a BHH be able to receive concurrently any other MaineCare Service that provides case management or care management or defines case management/care management as a bundled component activity within any Section of MBM Chapter 101?

CMS views Health Homes and TCM as a duplication of service. MaineCare plans to structure the service to avoid duplication with similar services, including TCM and Community Integration. As noted in previous responses, MaineCare is reviewing how best to support consumer choice while promoting transformation of existing services to the Health Home model.

Other

68. Within payment reform models, how will the state assess performance if consumers move between one model and another within a given month/year?

MaineCare will review this as a part of its evaluation plan for Stage B Health Homes.

69. Will Stage B be in a pilot phase like Stage A?

Technically, neither Stage A nor Stage B Health Homes are a pilot; they are/will be options under the Maine's Medicaid State Plan. Health Homes differ from other State Plan amendments in that these services receive an enhanced 90/10 match during the first eight quarters of operation. Following those initial eight quarters, Mainecare must review the cost and benefit of continuing to provide the service within the standard federal match rate.

70. If Stage B Health Homes services are not designed to end after a specific period of time, is there a time limit on the funding available for the PMPM stipends to the Health Homes?

Payment for Health Home services will continue as long as MaineCare elects to include the service as a Medicaid State Plan Option.

71. If there is no time limit to the funding available for the PMPM stipends, is there a federally specified end date to the initial level of funding?

The enhanced match rate ends eight quarters after implementation of the service.

72. What non-reimbursement support and leadership does the Department intend to provide to Primary Care Practices to help them make the cultural shift to integrated care with Stage B CCT's?

To be determined; resources may be available via the State Innovation Model to target provider and leadership support.

73. Under the list of Core Standards on page 6, the second standard is "population risk stratification and management". Can the Department describe how this informed research, analysis and management of a Health Home's population will work in concert with the future ACC's population risk stratification and management?

Health Homes Stage B, as in Stage A, will be expected to use population management tools to identify members in need of increased care coordination, referral, and follow up. This happens at the service level and, while population-based, results in service interventions for individuals at the practice/CCT level.

Accountable Communities will also be built on primary care, and may choose to build on Health Homes because of their commitment to this population-based model. However, Accountable Communities, in order to participate in shared savings, will seek to improve quality and reduce cost across the entire spectrum of core services that go into the calculation of total cost of care. This involves a commitment to system improvement beyond the primary care or CCT practice and includes imaging, diagnostics, hospital admissions, and many other services. Excellent primary care and care coordination remain the foundation and drivers for quality and health care improvement, but other providers and systems must be engaged to impact broad quality measures and total cost of care.

74. How will decisions regarding disease management and patient education be made for a Stage B Health Home population when that same population is folded into an ACC later this year?

MaineCare sees Health Homes as innovation at the point of service, whether in the primary care setting or as part of an enhanced and integrated community mental health system. Accountable Communities will not be paid to deliver services; they are envisioned as a mechanism to engage and improve systems of care. Mainecare sees these entities as having related but distinct functions.

75. Can the Department define what it means by "access"? Does "access" refer to eligibility access for services not currently covered under the MCBM, but may be covered under the flexibility allowed in Section 2703 of the ACA, or does this refer to a member being accepted into a PCP's practice regardless of his/her challenges, or does this refer to the increased capacity to link a member to all services through the work of the Stage B CCT?

Access is defined broadly as the ability of a member to obtain services when and where he/she needs them. This may mean enhanced hours of operation, open or more flexible scheduling options, access to a team member during non-office hours, etc. Access in this context does not mean eligibility.

76. With regard to Core Standard #7 on page 6, will the contemplated "formalized discharge/transition procedures" be standardized by the Department for all providers, differentiated only by the type of facility discharging the members? For example, it would seem that the discharge/transition procedure for a hospital would look quite different from the discharge/transition procedure from a juvenile justice facility, but that all hospitals and all juvenile justice facilities would have the same procedures.

MaineCare will develop expectations and definitions for each of the core requirements. Please feel free to include these and related comments/suggestions as part of your feedback to the RFI.

77. With regard to Core Standard #9, what criteria will the Department use to determine if a Stage B Health Home has "commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services"

MaineCare will develop expectations and definitions for each of the core requirements. Possibilities may include engagement in learning collaboratives on cost reduction strategies, provider adoption and implementation of

procedures/policies that indicate provider-initiated cost savings initiatives, participation by providers in specific MaineCare cost-saving initiatives, etc.

78. Has the Department focused on the White Paper entitled "*Customizing Health Homes for Children with Serious Behavioral Health Challenges*" prepared for the U.S. Substance Abuse and Mental Health Services Administration by Sheila A. Pires of the Human Service Collaborative (March, 2013) and determined how its recommendations may support and enhance Maine's Stage B Health Homes model for children with serious emotional disturbance?

Yes, the department has reviewed this paper. Please feel free to offer any suggestions or highlight any of these findings in your RFI comments.

79. Similar to how the center of leadership for Stage A Health Homes rests with the primary care practice, can the department more clearly articulate that the leadership for Stage B Health Homes rests with the Stage B CCT?

Both the BH CCT and the primary care provider will provide leadership within their spheres of expertise. However, current thinking is that members will be identified and assigned to the Health Home based on the relationship they have with the BH CCT.

80. Will APS still be involved in managing these services even after they are embedded as CCT services and reimbursed differently? If a behavioral health provider becomes a Stage B CCT, how will its services, formerly known as TCM or ACT, be managed in terms of both authorizations for initial service and utilization review?

Details regarding authorization of services have not yet been determined.

Appendix A: **Stage B Eligibility Criteria**

Eligibility Criteria: Children	
Section 65	**Children's Home and Community Based Treatment** **Multi-systemic Therapy** **Functional Family Therapy** **Children's Assertive Community Treatment** **Behavioral Health Day Treatment**
Section 13	**Case management services for members children with behavioral health disorders (*under review*)**
Section 97, Appendix D	**Child Mental Health- Level I** **Child Mental Health – Level II** **Intensive Mental Health for Infants and/or Toddlers** **Crisis Stabilization Residential Services** **Therapeutic Foster Care** **Therapeutic Foster Care- Multidimensional** **Temporary High Intensity Service**
Eligibility Criteria: Adults	
Section 17	**Community Integration Services** **Community Rehabilitation Services** **Intensive Case Management** **Assertive Community Treatment** **Daily Living Support Services** **Skills Development Services** **Day Supports Services** **Specialized Group Services**
Section 97	**Appendix E** **Appendix F: for Persons with Severe and Prolonged Mental Illness ONLY**